Healthpoint

Information from the Division of Health Care Finance and Policy

Division of Health Care Finance and Policy

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HOME HEALTH: AN EMERGING CHALLENGE IN HEALTH CARE

Home health is one of the fastest growing areas in health care. Nationally, total home health expenditures more than doubled from 1990 to 1996 (from $13.1 to $30.2 billion), mostly from Medicare and Medicaid. In contrast, nursing home expenditures increased by 54% (to $78.5 billion), and hospital care expenditures by 40% (to $358.5 billion).[1] Among the main drivers of rapid growth in home health are shorter lengths of hospital stays, a shift toward less expensive care sites and patient preference for treatment and support in home and community settings.

The rapid expansion in home health care challenges policy makers to balance two objectives—control public spending and ensure access to quality care. The Health Care Financing Administration (HCFA) is developing a new payment system for Medicare home health services to discourage fraud, promote quality and control spending. In the absence of information systems on structure and outcomes of home health, we can make only educated assumptions about the effects of a new reimbursement system on home health care. Past experience, however, suggests that changes in one area may produce some unintended effects throughout the system.

The impending changes in Medicare home health reimbursement have important implications for Massachusetts. This issue of *Healthpoint* discusses recent trends and policy changes, and highlights implications for home health providers, recipients and policy makers. The upcoming changes will be dramatic, and may affect the structure and financial health of home health agencies, and the quality of the care they deliver.

What Constitutes Home Health Care?

Home health care is provided to individuals in their place of residence to promote, maintain, or restore health or to maximize independence while minimizing the effects of disability and illness. Currently, all homebound elderly and disabled Medicare beneficiaries are eligible for free unlimited visits prescribed by a physician; Medicaid and private insurers cover these services as well. Home health services range from high-intensity skilled nursing care to lower-intensity, custodial services such as assistance in bathing and eating. These services are grouped into six broad categories: skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social work. In Massachusetts, Medicaid reimburses home health agencies for all services except medical social work. Massachusetts Medicaid home health utilization data available for the three most recent years are shown in Figure 1 on page 2.

Recent Statistics

The 1994 National Home and Hospice Care Survey reported 9,800 agencies providing home health services in the United States.[2] Nearly three-quarters of the 3.6 million consumers of home health services in 1996 were elderly (age 65 and over) and about two-thirds were female.[3]

Public expenditure on home health has grown tremendously in the past decade. While most private insurers and HMOs cover home health care, Medicare is the largest purchaser of home health services and its share of total expenditures has grown over the last few years. National Medicare spending for home health services exceeded $17 billion in 1995 compared to $1.8 billion in 1987. Medicaid spending on home and community-based services more than quadrupled during the same period, totaling $9.7 billion in 1995 compared to $2.1 billion in 1987 (see Figure 2 on page 3).[4]

In Massachusetts, Medicare spent about $629 million for home health care in 1995 and Medicaid, about $125 million. Massachusetts ranked eighth highest in Medicare home health spending per enrollee, and fourth highest in Medicaid spending. In 1993, Massachusetts was among only ten states where both Medicare and Medicaid spending per enrollee exceeded national medians.[5]

Current Issues in Home Health Care

HCFA recently launched two initiatives to revamp home health care—Operation Restore Trust to reduce fraud and abuse; and the National Home Health Agency Prospective Payment Demonstration Project with an intent to eliminate fraud and abuse, to control growth in expenditure and to improve the quality of home health services. With Medicare paying for such a large portion of services, changes in Medicare policy will have a great impact on the home health industry overall.

Fraud and Abuse. Overbilling for services has been a major issue in home health. Operation Restore Trust (ORT), a two-year investigation by the U.S. Department of Health and Human Services in 1993-94, reported massive fraud and waste in Medicare billings in the five states studied: California, New York, Florida, Texas and Illinois. The "problem" agencies tended to be for-profit, closely held corporations with owners who were involved in interlocking, self-referring businesses.

In a 1997 audit in Massachusetts, HCFA found some overpayments but no cases of fraud. In an effort to prevent fraud in the state, the Attorney General has proposed licensing people who provide home health care, and establishing consumer protections. The Governor has also filed legislation requiring licensure of home health agencies and creating a registry of abusive workers. Currently, the Department of Public Health maintains a registry of fraud and abuse by nursing home workers.

Prospective Payment System. The revelations of ORT occurred just when Congress was looking for ways to control Medicare spending. Congress wanted to switch to a prospective payment system analogous to the one that Medicare now uses to pay hospitals. "Prospective payment" is a system in which a price is set for a certain type and amount of care and the provider is paid that price regardless of the resources needed to provide the services. While the provider is exposed to some financial risk in providing the service, the system also offers them financial rewards incentives for providing services at lower costs.

Historically, HCFA has used cost-based reimbursement for home health services. Cost based reimbursement offers providers few incentives for cost-

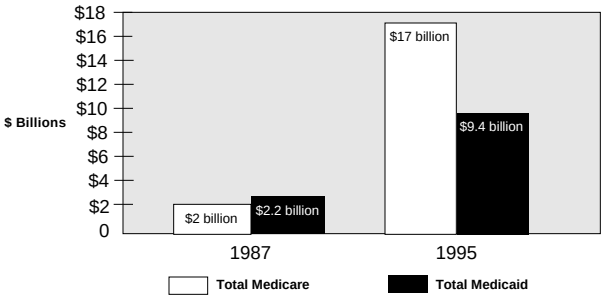
Figure 1: Medicaid Home Health Utilization in Massachusetts

	FY94		FY95		FY96	
Number of Agencies	**128**		**152**		**167**	
Service	**Number of Visits**	**Costs (millions)**	**Number of Visits**	**Costs (millions)**	**Number of Visits**	**Costs (millions)**
Nursing Care	622,399	$34.8	690,457	$38.8	719,206	$40.5
Home Health Aide	2,339,301*	$43.8	2,482,370*	$46.7	2,370,081	$44.6
Physical Therapy	69,475	$3.7	74,320	$4.2	75,631	$4.2
Speech Therapy	26,689	$1.6	27,647	$1.7	26,148	$1.6
Occupational Therapy	24,309	$1.4	25,276	$1.5	24,890	$1.5
Total	**3,082,173**	**$85.5**	**3,300,070**	**$92.8**	**3,215,956**	**$92.4**

* Home health aide services are measures in terms of hours.
Note: This table includes those agencies which filed Medicaid claims.
Source: Massachusetts Division of Health Care Finance and Policy

conscious behavior and, as substantiated by the findings of ORT, allows room for fraudulent practices. In the Balanced Budget Act of 1997, Congress created an interim payment system (IPS), freezing Medicare reimbursement at the 1993-94 rates before ORT began, with provisions for annual revisions for market inflation and patient case mix. It requires home health agencies to secure surety bonds of at least $50,000 to be eligible to provide home health services under the Medicare and Medicaid programs. Both of these IPS provisions impose economic strain on relatively low-cost, non-profit agencies like many of those in Massachusetts. The IPS will be in place until October 1, 1999, as HCFA moves toward prospective payment.

Figure 2: Growth in Federal Spending on Home Health



Source: Genevieve Kenney, et al. *Health Affairs* , Volume 17, Issue 1, 1998, p. 201-212.[4]

The HCFA demonstration project to test the extent to which prospective rate setting increases efficiency of Medicare home health care is now in its third and final year. Ninety-one agencies, including 11 in Massachusetts, are participating. If this system is adopted permanently, reimbursement rates, based on findings from the demonstration, would be set prospectively for a 120-day episode of care, irrespective of the number of visits and services per visit provided by an agency.

At this stage, it is unclear whether Medicaid would adopt the Medicare prospective payment system. Currently in Massachusetts, Medicaid pays home health agencies at a class rate for each service provided, with an add-on for certain high-volume providers.

Inequities in the System. The cost-based reimbursement system is inequitable in that it pays low-cost, efficient providers less than potentially inefficient high-cost providers. Agencies in Massachusetts provide care for relatively low average payments per visit and per patient. According to 1995 HCFA data, the average payment per visit was $50, compared to a national average of $62. The $4,730 average payment per patient was slightly above the national average of $4,473; but much lower than the $7,217 in Texas.[6] Because prospective rates would be determined based on historical costs, Massachusetts providers are likely to face this inequity even under the new system. To the extent that this imbalance reflects waste and inefficiency rather than true cost differences, should prospective rates be based on something other than historical costs?

Disparities also exist between Medicare and Medicaid reimbursement rates. For example, Medicare pays Massachusetts providers between $93 and $117 per skilled nursing visit, while Medicaid pays about $57. These differences create incentives for providers to maximize Medicare reimbursement to augment their revenues. If prospective payment threatens revenues by reducing the financial benefit of this "cost-shifting," providers' attention may turn more forcefully to reimbursement from other payment sources, particularly Medicaid. Further, changes in Medicare coverage mandated by the Balanced Budget Act may place additional pressure on Medicaid. Federal changes in Medicare payment practices may therefore raise important policy issues at the state level.

Performance Monitoring. Cost containment efforts raise concerns about access to quality care. Under prospective payment, providers may be impelled to provide fewer services for a set rate per episode, or to avoid patients needing high-intensity services. Consequently, more patients may need to use nursing home care which is more expensive, both for the system as a whole and for Medicaid. While the prospective payment system may reduce waste, it may also jeopardize the quality of care. Monitoring access to and quality of home health care therefore assumes greater significance, especially when only a limited and fragmented information system exists for home health.

HCFA has sponsored the Outcomes and Assessment Information Set (OASIS) initiative to develop outcome measures aimed at improving the quality of home health services. OASIS collects longitudinal information on 79 patient-based, health-related quality indicators. HCFA anticipates the release of the final Conditions of Participation, that will require the use of OASIS for Medicare and Medicaid-certified home health agencies, in the second half of 1998.

What Lies Ahead?

Introduction of a prospective hospital payment system in Medicare contributed to a trend of shorter hospitalizations and to other changes, probably including rapid and relatively unregulated growth in home health care expenditures, while setting in motion major reorganization within hospital care itself. This and the persistent pressure for cost containment in every segment of health care has led to the impending implementation of prospective payment for home health services. If past is prologue, we can anticipate that policy makers will soon be faced with some critical questions: Despite best intentions, will home health agencies be driven to limit access and compromise quality? Will information systems be adequate to track the impact of the change on access and health? With Medicare rates less attractive, will there be upward pressure on Medicaid rates? Will independent, non-profit agencies seek refuge in alliances with for-profit chains or other partners with deeper pockets? Should we expect the "balloon" of health care costs to bulge at other edges such as nursing home costs and family caregiver burden, as we try to restrain home health costs? As the home health sector continues to evolve, answers will become more apparent, and policy remedies may necessarily involve not just this area, but all of the interrelated areas of health care**.**

Endnotes

1. Health Care Financing Administration, Office of the Actuary. Freestanding facilities only. Additional services of this type are provided in hospital-based facilities and are counted as hospital care. In 1996, home care provided by hospital-based facilities amounted to $7.8 billion; the comparable nursing home figure was $9.0 billion.
2. 1994 National Home and Hospice Care Survey, National Center for Health Statistics.
3. Health Care Financing Administration, Office of the Actuary.
4. Genevieve Kenney, et al. "State Spending for Medicare and Medicaid Home Care Programs," *Health Affairs*, Volume 17, Issue 1, 1998, p. 201-212. According to this article, Medicaid spending on home care in Massachusetts in 1995 was about $577 million, which includes expenditures under Medicaid's home and community-based waiver programs as well as home health services discussed in this article.
5. Although it fell in the high per enrollee spending category, Massachusetts has among the lowest per visit costs. The high per enrollee spending is due to a higher number of visits per enrollee.
6. Health Care Financing Administration and The Wall Street Journal

Further Reading

Genevieve Kenney and others, "State Spending for Medicare and Medicaid Home Care Programs," *Health Affairs*, Volume 17, Issue 1, 1998, p. 201-212.
Carol Gentry, "Region's Home-Care Firms Face Being Punished for Their Efficiency," *Wall Street Journal,* January 7, 1998, p. NE1.

Did you know?

New Information on Hospital Trends

The downward trend in hospital discharges may have leveled off in 1997. The Division of Health Care Finance and Policy's 1997 data base contains 764,000 discharge records from 83 Massachusetts acute care hospitals, a drop of over 100,000 discharges since 1991 and 1992 when total discharges reached nearly 900,000 annually. The Division will continue to monitor this data to confirm whether the decline is indeed leveling.

Other data findings:

- Asthma continues to be the most frequent principal diagnosis among hospitalized children age 1-17 accounting for nearly 30% of the 9,200 asthma admissions in 1997.
- Heart transplant hospitalizations were the most expensive cases with average charges of $250,000 per patient compared with $10,000 for acute patients overall. Most of the 63 heart transplant patients in 1997 were age 25-44 and about 41% of these patients resided outside Massachusetts.
- 107 very low birthweight neonates were the second most expensive cases with average charges of $235,000 and a three month hospital stay.
- Falls among the elderly age 65 and older represented almost two-fifths of the 38,000 nonmedical injury related discharges accounting for about $170,000,000 acute hospital inpatient dollars. Eighty percent of falls among the elderly were in the age 75 and older group, while those age 65-74 accounted for the other 20%. Most of these patients needed further care in subacute facilities or at home and continued to accrue charges beyond the $170,000,000 in acute care charges.

Source: Massachusetts Division of Health Care Finance and Policy

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